

**TWENTIETH ANNUAL
SOUTHERN SURETY AND FIDELITY CLAIMS
CONFERENCE**

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FIDELITY UPDATE

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A. OCCURRENCE

Thornburgh Insulation, Inc. v. J.W. Terrill, Inc., 236 S.W.3d 651 (Mo. App. E.D. 2007).

An employee of the Plaintiff embezzled money from two related companies. The Plaintiff had commercial crime policies with Travelers. The policies contained a \$50,000 limit of liability for each “occurrence” of employee dishonesty. The policies defined “occurrence” as “all loss caused by or involving, one or more ‘employees,’ whether the result of a single act or series of acts.”

The embezzlement stretched from 2000 to 2002. The employee made out a series of checks to two fictitious companies and applied the signature stamp of one of the owners of the companies. During this time, the employee deposited 37 fraudulent checks from one company in the amount of \$745,800 and 26 checks from the other company in the amount of \$508,350. The companies discovered the embezzlement and notified Travelers of the loss.

Travelers investigated the claim and also hired an outside forensic accounting firm to investigate the claim. After its investigation, Travelers issued a check to each company for the \$50,000 limit of liability. The companies sued under breach of contract to recover the remainder of their loss arguing that each check was a separate occurrence and they should therefore recover up to \$50,000 for each fraudulent check. The companies moved for summary judgment and the trial court granted the summary judgment and ordered Travelers to pay the full amount of loss to each company.

On appeal, the court reversed the trial court finding that the companies argument that each check was a separate occurrence was faulty. The companies claimed that because each check required a series of actions (including writing out the check, stealing the signature stamp of the owner, applying the stamp, and depositing the check) this constituted a series of acts and hence one occurrence. In reversing, the court noted that the definition makes clear that an “occurrence” consists of “all loss” caused by an employee. The court found that the loss was caused by an embezzlement scheme, consisting of a series of acts by one employee and therefore the policy limit applied and reversed the summary judgment.

Employers Mut. Cas. Co. v. DGG & CAR, Inc., 183 P.3d 513 (Ariz. 2008).

The insured was covered under policies provided by Employers that covered employee dishonesty. The insured discovered that an accounting employee had embezzled more than \$500,000 during a five year period by forging company checks. The policies contained a limit that they would pay up to \$50,000 in any one “occurrence.” Under the policy, occurrence was defined as “all loss caused by, or involving, one or more ‘employees,’ whether the result of a single act or a series of acts.” Whether this embezzlement scheme constituted one occurrence or multiple occurrences was the center of the dispute.

The insured argued that each act of theft over the five years was an occurrence. Employers countered that the embezzlement was the result of a “series of acts” and thus one occurrence. The trial court found in favor of the insured, the court of appeals

reversed and the case proceeded to the Arizona Supreme Court. In interpreting the terms of the insurance policy, Arizona follows a “rule of common sense.” Additionally, the court noted that even though other courts from other states may have interpreted this policy provision in different ways, it did not necessarily render the term ambiguous.

In finding for Employers that the embezzlement was a series of acts such that it constituted one occurrence under the policy, the court noted that courts in Maryland, Colorado, Texas, Illinois, Florida and Louisiana reached the same conclusion. The insured attempted to argue that various terms in the policy were ambiguous, but the Arizona Supreme Court was not persuaded.

The insured did make a last ditch effort to argue that the standard definition of occurrence covering a series of acts as one occurrence could mean that a situation involving multiple employees involved in unrelated thefts would result in one occurrence under the policy and this result would be unjust. The court declined to definitively address that issue stating that it did not need to address it to reach its result. However, it seemed to indicate that in a situation involving multiple employees conducting unrelated thefts would likely not be a series of acts and thus just one occurrence.

Madison Materials Company, Inc. v. St. Paul Fire & Marine Insurance Company, 523 F.3d 541 (5th Cir. 2008).

The Plaintiff was insured for over 10 years with the Defendant. The policies contained protection for employee theft. At the end of those 10 years, the Plaintiff discovered that its financial officer had embezzled money from the Plaintiff in each of the previous 10 years. The employee opened fraudulent checking accounts and wrote checks and deposited them into those accounts. He also developed a payroll tax scam, but this only netted him \$26,000. The main embezzlement scheme totaled \$1,469,148.53.

The Plaintiff notified the Defendant of its total loss upon learning of the embezzlement. The Defendant acknowledged receipt of proof of loss and that it was a valid claim. However, the Defendant paid only \$350,000 which was the limit for the insurance. Once again, the dispute focused on whether this embezzlement scheme was one occurrence under the policy. The district court ruled it was one occurrence under the policy. The court based its ruling on the policy language that an occurrence was “an act or series of acts.” On appeal, the Fifth Circuit ruled that this policy language was clear and this was a series of acts and constituted one occurrence under the policy. Therefore, the Defendant did not have to pay beyond the \$350,000 limit.

B. BAD FAITH

Heritage Corp. of South Florida v. National Union Fire Ins. Co. of Pittsburgh, PA, 2007 WL 4142788 (11th Cir. 2007).

Heritage sued for statutory bad faith arising out of an insurance coverage dispute for failing to properly investigate and pay earlier claims filed by Heritage. Heritage alleged National Union was required to cover a \$3.8 million loss caused by employee dishonesty and fraud under various policies. The trial court granted summary judgment

for National Union on all but one of the policies which provided \$1 million in coverage. National Union made an offer of judgment under Florida law for \$250,001. Heritage rejected the offer.

The case proceeded to jury trial and the jury found Heritage was covered for an insurable loss of \$80,310. The award was reduced by a deductible of \$25,000. The court initially entered a judgment for Heritage for \$55,310, plus pre-judgment interest in the amount of \$17,903.92. However, National Union sought its attorneys' fees stemming from its declined offer of judgment. The Court agreed and entered a final judgment for National Union in the amount of \$352,415.56.

Despite the adverse judgment based on the fees, Heritage filed a bad faith suit against National Union and its parent AIG, for not attempting in good faith to investigate and settle with Heritage for its claims under the bonds. The district court dismissed the suit because it did not believe Heritage could demonstrate any set of facts that showed the underlying case was resolved in its favor. The 11th Circuit reversed the district court finding that the attorneys' fees award should not have factored into the district court's decision. The 11th Circuit held that even though the final judgment was adverse to Heritage, the jury determined Heritage had suffered a loss in a specified amount that National Union had failed to pay. Accordingly, this was sufficient to state a viable claim.

C. FORGERY COVERAGE

Milwaukee Area Technical College v. Frontiers Adjusters of Milwaukee, 752 N.W. 2d 396 (Ct. App. Wisc. 2008)

The Plaintiff hired a company to process the Plaintiff's workers compensation claims. The owner of the company evaluated the claims and was to make payments from a bank account controlled by the owner. The Plaintiff replenished the money in the account by periodically sending checks to the owner of the company. The owner used this set up to steal money from the account. The owner would tell the Plaintiff he sent checks to health-care providers, when in reality he had not done so. He made a dummy check ledger that he sent to the Plaintiff which the Plaintiff used as a basis to replenish the account. The owner then issued checks from that account for his own use. The Plaintiff did not discovery this scheme until the owner had siphoned off \$1.6 million.

The Plaintiff brought suit against St. Paul arguing that this conduct was covered because it was a "forgery or alteration" of "covered instruments." The Plaintiff did not dispute that the checks were not forgeries under the policy. Rather, the Plaintiff argued that the case involved alterations because the check ledgers were altered from the actual check ledgers. In affirming summary judgment for St. Paul, the appeals court declined this argument noting that the check ledgers were not "covered instruments" under the policy definition of "checks, drafts, promissory notes or similar written promises, orders or directions to pay a sum certain in 'Money.'" Additionally, the court added that the checks themselves were not altered as the owner of the company, who had control over the account, intended the checks be made payable in the manner which he made them out and he signed them and made them out to real people.

Merchants Bank and Trust Co. v. Cincinnati Insurance Co., 2008 WL 728332 (S.D. Ohio 2008).

Plaintiff Merchants used a third party to provide check handling services to the bank. In December 2003 the third party received a cashier's check allegedly issued by MBT and payable to Richmond Motors in the amount of \$159,200 from the Federal Reserve. The third party processed the check and sent the information to Merchants the next day. By then, the funds from the check had been withdrawn from the Merchants cashier's checking account and transferred to U.S. Bank where the check had been negotiated and deposited.

Merchants discovered the check was illegitimate and the check was returned to the Federal Reserve in an attempt for Merchants to get a credit. Merchants received a credit for \$159,200. U.S. Bank then filed suit to recover the amount from Merchants. The parties settled the case for half of the \$159,200. In the settlement, the parties agreed the check was counterfeit. Merchants then sought reimbursement for the remaining \$79,600 from Cincinnati under its bond.

The bond provided for coverage under section D for loss resulting directly from forgery or alteration of any negotiable instrument. The court found that no coverage existed under section D because the loss did not result directly from the forgery. Because Merchants was reimbursed from the FDIC for the full amount and did not sustain a loss until it agreed to a settlement with U.S. Bank, the loss was not caused directly by the forgery.

However, the court did find that coverage existed under the less stringent causation standard in section E. Section E covered loss by reason of the insured action in good faith acted upon any written instrument which proves to have been a forgery or counterfeited. The court noted that this standard did not require a direct loss, only loss by reason of a forgery. The court found Merchant acted upon a document which proved to be a forgery. Therefore, the court found that Merchant could recover under the bond under section E for the forged cashier's check.

D. DIRECT LOSS

Lee, Black, Hart & Rouse, P.C. v. Travelers Indemnity Co., 662 S.E. 2nd 889 (Ct. App. Ga. 2008)

An employee of the Plaintiff law firm allegedly stole money from the firm's escrow account via a "staggeringly complex" check kiting scheme. The law firm discovered this scheme and reported it to Travelers. Travelers issued a policy that covered losses from employee dishonesty up to \$250,000. The law firm claimed a net loss of \$325,885.64 and sought recovery under the policy up to the limits. Travelers paid the firm \$151,500.84.

The difference that was claimed, but not paid by Travelers focused on improper checks that were deposited into the firm's escrow account. Travelers contended that the policy only covered loss caused by employee dishonesty. Since the checks were actually deposited back into the firm's account, there was no loss. The trial court

agreed with Travelers and found that these were not funds that came out of the firm's pocket, they were not losses. On appeal, the Court of Appeals agreed and affirmed the findings of the trial court.

Citizens Bank and Trust Company v. St. Paul Mercury Insurance Company, 2007 WL 4973847 (S.D. Ga. 2007).

In this case, a Georgia bank discovered that one of its branch vice presidents had been involved in an embezzlement scheme for a period of approximately thirteen years. The embezzlement scheme involved the branch vice president executing fraudulent loan instruments in the name of bank customers. As the scheme grew, many of the loans were used to pay the principal and interest on prior loans as they became due. After investigation, it was determined that there were thirty-nine outstanding fraudulent loans totaling approximately \$1,450,000.00. Of these thirty-nine loans, thirty-one were used entirely to cover the principal and accrued interest owed on prior fraudulent notes. Five of the remaining notes were converted entirely to cash for the benefit of the branch vice president, and the remaining three were used partly to cover prior fraudulent notes and partly for cash. Of the \$1,450,000.00 in outstanding principal, only \$884,000.00 represented a depletion in the bank's loan proceeds over the course of the scheme. The balance was interest.

Following discovery, a claim was made under the bank's Financial Institution Bond. The insurer determined that the "direct loss" to the bank was \$884,000.00 and paid that amount to the bank, less the policy deductible. It determined that the remaining amount of the claim was excluded based upon the policy exclusions for "potential income, including but not limited to, interest and dividends, not realized by the Insured," and "indirect or consequential loss of any nature." The Court analyzed the dispute as one of what was the "direct loss" to the bank. The bank argued that its direct loss was the full \$1,450,000.00 because it wrote off that entire amount from its books, as it reflected a reduction of the bank's assets by that amount. It argued that the interest received on prior fraudulent loans was "realized income" and strongly emphasized in its argument the concept of generally accepted accounting principles.

By way of contrast, St. Paul presented a "cash-out-the-door" theory contending that the actual depletion of bank funds caused by the dishonest act should be the measure of "direct loss" under the Bond. On this theory, St. Paul argued that when the old loans were rolled over into new loans, the branch vice president was merely concealing his earlier thefts with fraudulent paper. No new direct losses were incurred by the bank because no additional funds were depleted. As a consequence, St. Paul argued that under the bank's theory, it would result in a windfall, which would allow it to realize "income" on the fraudulent loans and thereby profit from the dishonest act of its own employee.

In resolving the conflicting positions, the Court initially noted that it was a case of first impression in Georgia, and other Courts which had considered the issue had reached conflicting conclusions. Nonetheless, the Court found that St. Paul offered the more persuasive interpretation of the Bond language. While the Court conceded that the bank had lost the "time value" of the money that was stolen and the income it would have earned on the funds had the loans been legitimate, the Court held that this was a

type of “indirect loss,” or “potential income,” that is excluded from coverage under the bond. It concluded by stating that “St. Paul only agreed to cover [the bank] for direct losses sustained, not to ensure that the bank received the benefit of bargains that never actually existed.”

E. DISCOVERY OF LOSS/POLICY COVERAGE FOR LOSSES THAT OCCURRED DURING PREVIOUS POLICY/OCCURRENCE

Superstition Crushing, LLC v. Travelers Casualty and Surety Co. of America, Case No. 2:07-cv-0694-HRH (E.D. Ariz. May 23, 2008).

The Plaintiff was insured through Travelers from 1999 through 2006. The first full policy period began on November 14, 1999 and the Plaintiff continued to be insured each year. For each year, Travelers issued a one-page renewal notice and a new Declarations page. The policies provided coverage for Employee Dishonesty which included a separate premium which changed year to year. The Employee Dishonesty policies contained a “limit of insurance” that limited the amount Travelers would pay for any one occurrence. Occurrence was defined using the standard definition that included all loss caused by or involving, one or more employees that was the result of a single act or series of act. The limit of insurance for employee dishonesty was \$250,000. The policies also contained a “non-cumulation” clause that read: “Regardless of the number of years this insurance remains in force or the number of premiums paid, no Limits of Insurance cumulates from year to year or period to period.” There were also “discovery of loss” provisions that stated that Travelers “will pay only for covered loss discovered no later than one year from the end of the policy period.”

In August 2006, Plaintiff provided Travelers with two proofs of loss caused by employee embezzlement—one for the 2004 to 2005 policy period and another for the 2005-2006 policy period. The proofs of loss totaled over \$750,000. Travelers acknowledged coverage for the loss, but limited the amount to \$250,000. Plaintiff also identified losses that occurred starting in 2001 for each policy period through 2004. Travelers declined coverage for those losses because the policies limited recovery for any one occurrence. Travelers contended it had satisfied its obligations by paying the \$250,000 limit. Plaintiff then sued.

The parties framed the issue as to whether the Plaintiff was entitled to recover up to the policy limits up to \$250,000 for each policy year, while Travelers contended Plaintiff was entitled to one policy limit of \$250,000. The Plaintiff argued it could receive for each policy period since Travelers issued a series of separate, independent insurance contracts. Travelers argued that this was in essence one continuous policy. However, the Court determined that this argument did not control the outcome of the case.

Instead of focusing on whether it was one continuous policy or a series of policies, the Court recognized that the policies would only pay for losses sustained during the policy period and this was limited by the Loss Sustained During Prior Insurance condition. This condition took the policy out of the occurrence form and made it a claims made policy. The court noted that the claims made policy is one where the carrier agreed to assume liability for any errors, including those made prior to the

inception of the policy so long as they were discovered during the policy period. The Loss Sustained During Prior Insurance provision stated that it was part of, not in addition to, the Limits of Insurance applying to this Insurance. Accordingly, the Plaintiff was restricted to the \$250,000 limits of liability under the policy. The Court recognized this policy would have allowed the Plaintiff to recover for prior losses over any year, but only up to a \$250,000 total.

American Auto Guardian, Inc. v. Acuity Mutual Ins. Co., 548 F.Supp. 2d 624 (N.D. Ill. 2008).

American was insured from 2000 to 2002 with three consecutive one year policies from General Casualty. Acuity then insured American from 2002 through 2005 with three consecutive one year policies. In August 2005 American discovered that its Vice President had been embezzling money from the company from July 2001 through June 2005. American reported the acts to Acuity and claimed coverage under the employee dishonestly provisions of the policies. Acuity did not deny that the acts were covered by the employee dishonesty provisions of the policies, but denied some of the claims based on the fact that the theft occurred under previous policies. There was no dispute that the General Casualty policies did not afford coverage as the policies provided that there would be no coverage for losses discovered after a switch in insurance providers which kicked in when American went with Acuity.

The issue in the case was whether all of the losses that occurred during the three one year policies provided by Acuity were covered, despite the fact that the losses were not discovered until 2005. Each Acuity policy contained a "discovery period provision" that limited coverage to losses that occurred within the policy period and are discovered within one year of the policy period. Each Acuity policy also contained a "prior loss provision" that provided coverage for any loss sustained during a policy period before the current policy period, so long as the current policy became effective at the termination of the previous insurance policy and recovery of the loss is barred by the previous policy's discovery period provision. Acuity admitted that losses that occurred within the 2005 policy were covered and eventually admitted that the losses that occurred during the previous one year policy were covered because of the prior loss provision. American contended that Acuity should have covered not only all of the losses that occurred during the time Acuity's three policies were in effect, but also the losses that occurred while General Casualty's policies were in effect.

In an attempt to expand the coverage and breadth of the discovery period provision, American argued that the two annual renewals of the policy with Acuity created a single three year policy instead of three one year policies. The effect of a finding in accordance with this argument would have been that losses that occurred in fall 2002, but not discovered until fall 2005 would be covered under the discovery period provision. The Illinois court rejected this argument finding that a renewal of a policy is in effect a new contract. In supporting its conclusion, the court noted that each policy period required a new premium and the new premium and the policy endorsements changed from year to year. Accordingly, the court found liability only under the last two one year policies issued by Acuity.

Machinery Movers v. Fidelity and Deposit Co. of Mary, 2007 WL 3120029 (N.D. Ill. Eastern Division, Oct. 19, 2007).

The insurer denied coverage under five commercial crime policies. The denial was based in part that the Plaintiffs failed to timely submit notice of their claims, which the Plaintiffs denied. The Plaintiffs argued the terms “as soon as possible” and “discovery of loss” were ambiguous and sought discovery from Defendants regarding the drafting and underwriting of the policies; any materials received from any insurance industry association and any reinsurer agreements regarding the policies. The Plaintiffs filed a Motion to Compel discovery of this information. The Defendants argued it was not likely to lead to admissible evidence because the terms were not ambiguous thus no parole evidence would be required to construe them.

The Court granted the Motion to Compel noting the very broad discovery parameters. The Court noted that it was discoverable if there was a “possibility” that the material sought will be relevant to an issue in the case. The Court reasoned that if the terms were ambiguous, then the Plaintiffs would be entitled to use this type of information to prove the meaning of disputed terms. The Court agreed that the Plaintiffs had not demonstrated that the terms were ambiguous, but nonetheless still allowed the discovery.

F. OBVIOUSLY UNLAWFUL CONDUCT

Sela v. St. Paul Travelers Companies, Inc., 2008 WL 495734 (Ct. App. Minn. 2008).

The Plaintiff was insured by St. Paul. The policy contained coverage for robbery that occurred through obviously unlawful acts. The Plaintiff did business with a person that claimed he bought houses very cheap, renovated them and then resold them for a large profit. He could do this he claimed because he had a special relationship with various lenders. This businessman sought loans from the Plaintiff and told him the loans would be secured by deeds and other collateral and for that he would return high interest on those loans.

The Plaintiff made numerous loans to this “businessman” totaling \$3,321,000. A large number of the loans were actually repaid to the Plaintiff. However, \$641,000 of the total amount was not repaid. Additionally, Plaintiff discovered there was no collateral for the loans. Plaintiff made a claim under his insurance policy. The Plaintiff claimed the loans were obtained through fraud and deceit and there was never any intention to repay them and the supposed collateral never existed. Accordingly, the Plaintiff claimed this was robbery that was covered under his policy.

St. Paul denied coverage because this incident did not qualify as robbery under the policy. Robbery was defined as “the taking of property from the care and custody of a person by one who has: (1) caused or threatened to cause that person bodily harm; or (2) committed an obviously unlawful act witnessed by that person.” Plaintiff contended that the fraud perpetrated against him was obviously unlawful.

Despite not knowing the frauds were committed, Plaintiff contended obviously unlawful just meant that they could be discovered at any time. The Plaintiff claimed that

looking back, the conduct was obviously unlawful. Not surprisingly, the court held that obviousness could not come in hindsight. Obviousness required immediate clarity and transparency. Thus, the Plaintiff's claims were properly denied.

G. STATUTE OF LIMITATIONS AND PROOF OF LOSS

Livonia Volkswagen, Inc. v. Universal Underwriters Group, 2008 WL 880189 (E.D. Mich. 2008).

Plaintiff was insured by Universal from November 2002 through November 2003 for employee dishonesty up to \$500,000. In May 2003 the Plaintiff believed one of its employees had engaged in dishonest behavior. Plaintiff claimed that while it was aware of this misconduct in May 2003, it didn't discover the extent of its losses until much later. The Plaintiff fired the employee in June 2003 and filed suit against him in September 2003. In December 2003, Plaintiff made a claim for coverage with Universal.

Plaintiff and Universal then went back and forth for the next year with Universal requesting additional documentation and Plaintiff providing some and also revising the amount of its loss several times. It was not until April 2004 that Plaintiff filed its proof of loss with Universal. It was not until July 2006 that Plaintiff filed the lawsuit. At issue in the case was a prerequisite in the policy that a proof of loss be filed within 4 months of discovery of the loss and a 1 year statute of limitations in the policy. Plaintiff missed both of these deadlines.

The 1 year statute of limitations was shorter than what was provided under Michigan law. Additionally, in 2007, the Michigan Office of Financial and Insurance Services prohibited the use of shortened statute of limitations in insurance policies. However, this prohibition did not apply to any policy in effect before 2007. Therefore, Plaintiff was not saved by this change. Accordingly, Plaintiff's case was barred by the 1 year statute of limitations in the policy.

In an attempt to get around the statute of limitations, Plaintiff argued that the back and forth between Plaintiff and Defendant constituted a waiver or estoppel which would prevent the statute of limitations from barring the case. However, Defendant never made any false representations or concealed anything to delay the filing of the action. Accordingly, the case was dismissed.

Magnolia Management Corp. v. Federal Insurance Company, 2007 WL 4124496 (W.D., La. 2007).

In this action a nursing home employed a bookkeeper who confessed to taking cash and checks from residents of the nursing home during 2002 and 2003.

Within a day or two following the discovery of the potential loss, the insured wrote its insurance agent a letter to the effect that an accounting discrepancy had been found and that the bookkeeper had confessed to taking money from patient accounts. The letter further provided that the amount of loss was unknown, and further asked that the insurer be placed on notice of the potential claim.

Ultimately, a proof of loss was filed by the insured, and in response to one of the questions on the proof of loss indicated that discovery of the loss was on January 26, 2004. Insurer later denied coverage for the loss and on February 15, 2006, suit was filed against the insurer.

The insurer later filed a motion for summary judgment citing a provision in the policy required that suit be filed within two years from “the discovery of such loss.” The Court concluded that such a provision in the policy was permissible under state law and concluded that “in the absence of a statutory prohibition, a clause in an insurance policy fixing a reasonable time to institute suit is valid.”

In an effort to avoid this policy provision, the insured argued that discovery of loss did not occur until its investigation into the “extent of loss” was completed much later, well within the two-year limitations period. The Court rejected this argument finding that “it is the discovery of the facts giving rise to a potential claim – not the discovery of the extent of loss – which triggers the date of discovery of such loss.” The Court found that more than two years before filing suit the insured knew both the identity of the wrongdoer and the actions which she had taken that might subject the insured to a loss. In fact, more than two years before suit was filed, a signed confession had been obtained from the wrongdoer.

Administrative Services of North America v. Hartford Fidelity and Bonding Company, 245 F. Appx. 384 (5th Cir. 2007).

In this case, a company employed a chief executive who it later learned had misappropriated funds from its bank and trust accounts. The company promptly notified the insurer on its Commercial Crime Policy. The crime policy provided that suit could not be filed sooner than ninety days after the filing of a proof of loss, but within two years from the date the loss was discovered.

Approximately three years after the filing of the proof of loss, the insurance company formally denied the claim. Approximately a year and a half later, the company filed suit against the insurer for, among other things, breach of contract for failure to honor its obligations under the policy.

The lower Court entered summary judgment in favor of the insurer and that was appealed to the Fifth Circuit Court of Appeals. There, the Court affirmed the summary judgment and the rationale upon which it was entered. The operative Texas statute rendered void the policy provision stipulating when suit must be filed. Nonetheless, that simply meant that the four-year limitations period provided by Texas common law would apply. Since suit was filed more than four years after discovery of the loss, it was barred under the Texas statute of limitations.

H. NOTICE OF LOSS

Gray and Associates, LLC v. Travelers Casualty and Surety Company of America, 2008 WL 822130 (D.Md. 2008).

The Plaintiff, Gray, served as limited receiver for Homemaxx. Homemaxx was insured under a commercial crime policy with employee dishonesty coverage by Travelers. The policy was in effect from September 2002 through September 2003 and would “pay only for covered loss discovered no later than one year from the end of the policy period.” This basically gave Homemaxx until September 2004 to discover an incident giving rise to coverage.

From October 2002 through May 2003, the main employee of Homemaxx stole large sums of money from Homemaxx’s escrow accounts. This loss caused another entity, First American Title Insurance Company losses. First American identified the employee as the wrongdoer and sought recovery from Travelers under the policy in August 2004. Travelers responded in September 2004 and informed First American that the policy was not a third party contract and therefore would not consider its claim on the policy. Homemaxx never filed a claim or notice of claim with Travelers.

First American then petitioned the court to appoint a receiver for Homemaxx. In December 2004, Gray was appointed as a limited receiver for Homemaxx. Gray did not report the loss to Travelers until May 2007 claiming he did not learn of the loss until January 2006. Travelers denied coverage because the notice of claim was untimely. Gray filed suit in July 2007 and Travelers moved to dismiss.

In an attempt to get around the failure to timely report theft, Gray argued that since he was not appointed receiver until after the notification deadline, the deadline could not be enforced and that Travelers had actual notice of the theft from the First American request within the time period. The court dismissed the case despite these arguments.

With respect to Gray’s argument that he could not have timely report the claim because the period expired before he was appointed, the Court did not directly address this argument. Instead, it focused on the fact that the proof of loss was not reported until 2007, despite the fact that he was appointed as limited receiver in December 2004. The Court may have been more sympathetic to Gray’s position if it had reported the loss immediately when he was appointed receiver. Gray claimed he could not have discovered the theft until 2006, but it was clear his appointment in 2004 was related to the theft and he was aware of First American’s claims.

Even though Travelers did have actual notice via the First American request, the Court held that the policy required that the insured provide the notice of loss. The Court also noted that Travelers response to that notice was that there could be no coverage because the insurance did not extend to third parties and it was not until 3 years later the insured notified Traveler’s of the loss. Therefore, the case was dismissed.

I. INSURER’S FAILURE TO DEFEND/ESTOPPEL

Citibank Texas, N.A. v. Progressive Casualty Insurance Company, 508 F.3d 779 (5th Cir. 2007)

In this case the general partner of a Texas limited partnership was an authorized signatory on the limited partnership’s account at Citibank. Over a period of months, the

general partner deposited sixteen checks payable to the limited partnership, totaling \$1,700,000.00, into his personal account. Needless to say the funds were used for the general partner's personal benefit, to the detriment of the limited partnership.

After the diversion of funds was detected, the limited partnership accused the bank of conversion for allowing the general partner to "misdeposit" the sixteen checks. Bank had a financial institution bond with Progressive, under the terms of which Progressive had the right, but not the obligation, to join in Citibank's defense of the case. It elected not to do so.

The state court in which the limited partnership filed suit against Citibank ultimately entered a partial summary judgment in favor of the limited partnership on the issue of liability. The court reasoned that Citibank had taken the checks with notice of the general partner's breach of fiduciary duty and thus was not a holder in due course. Before the damages phase of the case was heard, Citibank settled with the limited partnership and then sought reimbursement from Progressive.

Under insuring agreement D of the bond, Progressive agreed to indemnify Citibank for "loss resulting directly from ... forgery or alteration of, or in any Negotiable Instrument ...". The bond's Unauthorized Signature Rider, supplementing insuring agreement D was modified as follows: "accepting, paying or cashing any Negotiable Instrument or Withdrawal Orders that bear unauthorized signatures or endorsements shall be deemed to be a Forgery under the Insuring Agreement." Since the state court held that the general partner's endorsement of the checks was unauthorized, Citibank contended that these checks were forgeries for purposes of insuring agreement D, as modified by the rider, and was thus entitled to recover under the bond. Progressive contended that it was not liable.

The District Court ultimately held for Citibank on two grounds. First, under the doctrine of collateral estoppel it rejected Progressive's argument that it was not bound by the State Court judgment. Alternatively, even if Progressive were not collaterally estopped the District Court found that the general partner's endorsements were unauthorized within the meaning of the bond language.

On appeal, the major issue concerned whether or not Progressive was bound by the finding of the lower court that unauthorized endorsements the general partner had occurred. Citibank cited language in General Agreement F which states that if Progressive "elects not to defend any causes of action, neither a judgment against the Insured, nor as settlement of any legal proceeding by the Insured, shall determine the existence, extent or amount of coverage under the bond." Progressive interpreted the language to mean that if it had elected to defend Citibank under the policy, the State Court judgment would have been a covered loss, but because it did not exercise its right to defend Citibank, Citibank remains obligated to prove its claim under the Bond as if the judgment or settlement had never happened.

The Fifth Circuit Court of Appeal found this argument to be "off the mark." It interpreted this language to mean that it prevents a judgment against the insured from determining "coverage," but it does not apply to "liability." In short, the language does not shield Progressive from the State Court's determination that the general partner's

endorsements were unauthorized. The Court was obviously unsympathetic to Progressive's position, finding that Progressive's interpretation would give it "a second bite at the proverbial apple" to relitigate the insured's liability every time it refused to participate in the underlying lawsuit. The Court said that this would give rise to the stereotypical "heads, I win, tails, you lose" option which would never give the insurer an incentive to join in the defense of a case.

A second argument raised by Progressive was that the definition of unauthorized endorsements was different under the policy than the definition under the Uniform Commercial Code which the State Court applied in finding liability against Citibank. In this regard, the UCC regards an endorsement as being unauthorized any time it is made "without actual, implied, or apparent authority." In contrast, the Bond defines an unauthorized endorsement as an "endorsement not reflected on the appropriate signature card or named in the Insured's records for the account or accounts in question." In addressing this argument, the Court stated that it need not reach the "abstract question" posed by Progressive because when Progressive opted not to join in the defense of the case "it intentionally declined – and thereby forfeited – any opportunity to raise this distinction."

J. MISC./DAMAGES

Sears Roebuck & Company v. National Union Fire Insurance Company of Pittsburgh, Pennsylvania, 2007 WL 2876149 (Cal. App. 2 Dist. 2007).

In this action, Sears Roebuck was issued an all risk theft insurance policy by National Union. For several years, Sears had used a company as its agent to buy from various media outlets the advertising time selected by Sears. There was no written agreement between Sears and the agent, but the normal course of dealing was that the agent would place orders for ad time with the media outlets. The media outlets considered Sears to be jointly and ultimately liable for payment. In practice, the agent would send Sears invoices for the ad costs, and Sears would transmit those funds to the agent, who in turn was supposed to pay the media outlets.

As time went by, the owner of the agency got in serious financial trouble, owing millions of dollars in back taxes to the federal government. He then took approximately \$24,000,000.00 which Sears had advanced to the agent for payment to media outlets and took off. Those media outlets demanded payment from Sears which Sears eventually settled most of the claims for approximately \$10.6 million.

Under its "Crime Guard" policy, Sears was covered for a loss of assets, including money, "for which [Sears] is legally liable, or which is owned or held by [Sears] in any capacity, whether or not [Sears] is legally liable therefor."

Sears thereafter made claim against National Union and the issue was joined after National Union denied the claim. Both parties moved for summary judgment, and the lynch pin of these arguments was based upon the theory of whether a trust relationship had arisen between Sears and the agent whereby the agent was holding monies it received from Sears "in trust," which would mean that Sears still retained an ownership interest in the monies until such time as they were paid to satisfy obligations to the

media outlets. The lower Court granted Sears' motion for summary judgment and denied the summary judgment motion of National Union.

On appeal, National Union argued that the funds that were lost were not "owned" by Sears. It advanced two arguments for this position. First, although it contended that no trust agreement existed, if there were such a trust, the agent holding the money from Sears "for the benefit of the media outlets" then ownership of the trust funds passed to the agent as trustee. Secondly, it argued that no trust was created because the agent commingled the money it received from Sears with monies received from other sources and accordingly, there was only a debtor-creditor relationship between the agent and Sears, not one of a fiduciary holding money in trust for the benefit of Sears.

The Appellate Court initially observed that the issue was one of whether Sears still owned the funds it transferred to the agent for payment to the media outlets because if the agent owned the funds, they could not have been stolen from Sears.

The Court ruled that it did not even have to reach the argument of whether or not a trust relationship existed. It relied upon the Restatement of Agency which provided that if commingling Sears' funds was only occurring in connection with monies the agent received from other clients, and there was no commingling of Sears' funds with the agent's funds, it was irrelevant as to whether a trust existed. The Court cited to section 398 of the First Restatement of Agency which provides that where one client's funds are commingled with another client's funds by an agent, but not with the agent's own funds, each of the clients owns the money in the account as a "tenant in common" with the other agent's clients.

The Court next examined two exclusions raised by National Union in support of its denial of coverage. First, National Union raised exclusion (e), which excludes coverage for a "loss or damage resulting from dissolution [theft] arising out of the giving or surrendering of assets in any exchange or purchase." Because the term "arising out of" is broadly construed, National Union argued that the theft arose out of the surrender of assets by Sears and its purchase of advertising time. Secondly, National Union invoked exclusion (n), which excludes coverage for "loss resulting from dissolution arising out of fraud which induces the Insured to make any purchase or sale." Because a Sears officer testified that Sears was fraudulently induced to transfer its money to the agent, National Union contended that this exclusion applies as well.

In its arguments, National Union attempted to use the phrase "arising out of" to stretch it from the underlying transactions with the media outlets (in which there was a purchase and sale) to cover theft by someone else – the agent. The Court dismissed this argument because the transaction at issue involved Sears' transfer of funds to its agent as part of Sears' purchase of ad time from the media outlets. The agent's theft of those funds, once they came into the possession of the agent, had to be considered an independent and intervening act separate and apart from the purchase transaction. Thus, the Court dismissed the argument involving exclusion (e).

With respect to exclusion (n) the Court also found it inapplicable as well. The Court rejected National Union's argument that Sears turned over money to the agent in reliance upon the agent's fraudulent representations that the media outlets would be

paid. The Court found that the agent's fraud did not induce Sears to make any particular advertising purchase. Instead, it merely induced Sears to rely on the agent to pay for those purchases.

With respect to the amount of the loss suffered by Sears, the Court affirmed the lower Court's finding that the loss was equal to or greater than the \$20 million policy limit. In contesting this point, National Union argued that because Sears had been able to settle most of its claims from the media outlets for \$10.6 million, and that there was no assurance that it would have to pay additional sums in the future to settle remaining claims, that Sears' actual loss was only \$10.6 million. The Court rejected this argument as well, finding that the actual loss which Sears suffered was "not affected by its later settlements with some of the media outlets." In reaching this conclusion, the Court followed the "New York rule," leading it to conclude that:

"Sears suffered a loss of more than \$20 million when [the agent] stole Sears' money that was intended to pay the media outlets. The policy contains no provision that determine the amount of actual loss according to any favorable settlements by the insured with third parties that might reduce the amount of the loss. Therefore, the fact that Sears was able to negotiate a favorable reduction in the amounts owed with some of the third party media outlets does not diminish its loss."